INDIANA CHILDREN'S SPECIAL HEALTH CARE SERVICES *(CSHCS)*
AUTHORIZATION REQUEST *(TEST FORM 08/25/10)*

Contact Name	Contact Phone/Extension	Contact Fax#	Date of Request
Service Provider Name/Address	Billing NPI # Tax ID#	Service Location Name/Address	
Participant Name	Participant #	Participant DOB	
Is this request for continuing service? Yes ☐ No ☐	Is this request for an amendment to an existing PA? Yes ☐ No ☐	If Yes, please give PA #	

CSHCS PA Unit Phone: (800) 475-1355 then select PA option, or (317) 233-1351 CSHCS PA Fax:(317) 233-1390

Please indicate the type of service for which you are requesting prior authorization below.

Inpatient ☐ Outpatient ☐ ER ☐ OR ☐ Therapy ☐ Supply ☐ DME ☐ Dental ☐ Transportation ☐

Home Health ☐ Pharmacy* ☐ Other ☐ _____

*Attn pharmacies: Please note that HCPCS procedure codes are required for supply/DME services. NDC codes are not accepted.

START DATE MM/DD/YY Required	STOP DATE MM/DD/YY Required	SERVICE CODE* Required for Dental/ Therapy/ Supply/DME **HCPCS/NDC**	SERVICE DESCRIPTION Required	TOTAL UNITS Required	PURCHASE Y/N	RENT Y/N	REPAIR Y/N	FRE-QUENCY If Applicable	DURATION If Applicable

*Please note HCPCS codes are required for supplies/DME.

PROVIDER COMMENTS/ADDITIONAL INFORMATION

DOCUMENTATION BEING SENT ***(REQUIRED)***

Phys Order ☐ Copy of RX ☐ Medical Notes ☐ Test Results ☐ Discharge Summary ☐ Medical Documentation Showing Need for Service ☐

Plan of Care ☐ Treatment Notes ☐ Admit Notes for Observation Stay ☐ History/Physical ☐ Other_____

PA STATUS ***(FOR CSHCS USE ONLY-OPTIONAL)***

REVIEWED BY	APPROVED ☐ DENIED ☐ MODIFIED ☐	PA#	DATE

PA NURSE COMMENTS